DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2019 (Rev. 7-06)

STATE OF WISCONSIN
Bureau of Quality Assurance

FOR OFFICE USE ONLY
License Number
License Fee
Caregiver Background Fee
License Type
Effective Date
Expiration Date

LICENSE APPLICATION
NURSING HOME, FACILITY FOR THE DEVELOPMENTALLY DISABLED OR INSTITUTE FOR MENTAL DISEASE

TYPE OF FACILITY
☐ Nursing Home
☐ Facility for the Developmentally Disabled
☐ Institute for Mental Disease

TYPE OF APPLICATION
☐ Initial
☐ Change of Ownership
☐ Replacement Facility

Completion of this form is required by s. 50.50.03(3)(b), Wis. Stats.; and HFS 132.14(2) and HFS 134.14(1), Wis. Admin. Code. The department will not issue a license until the applicant has supplied all requested information. The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.

I. GENERAL INFORMATION

Name – Facility

Previous Name (if applicable)

Street (physical) Address

City	County	State	Zip Code

Mailing Address (if different from physical address)

City	State	Zip Code

Telephone Number	FAX Number

E-mail Address

LEVEL OF LICENSE

HFS 132	HFS 134
☐ A. Skilled Care – Nursing Home ☐ B. Intermediate Care – Nursing Home ☐ C. Skilled Care – Institute for Mental Disease (IMD) ☐ D. Intermediate Care – Inst. for Mental Disease (IMD)	☐ E. Facility for the Developmentally Disabled
Licensed Bed Capacity	Fiscal Year End Date

TYPE OF CERTIFICATION

☐ Medicare (Title XVIII) ☐ Fully Participating ☐ Distinct Part ☐ State Licensed only (no certification)

☐ Medicaid (Title XIX)

☐ Medicare and Medicaid (Dual Certification)

II. ADMINISTRATION

A. ADMINISTRATOR

Status:

☐ Permanent ☐ Acting (temporary and unlicensed) ☐ Interim (temporary and licensed)

☐ QMRP (Only if facility is licensed as an FDD for 16 or fewer beds.)

Name – Administrator	License No.	Begin Date

Indicate if the administrator is also the DESIGNEE (Person authorized to accept personal service and receive registered and certified mail.) If NO, complete the Designee Section. ☐ Yes ☐ No

B. DESIGNEE

Name – Designee	Title	Begin Date

C. DIRECTOR OF NURSING

Name – Director of Nursing	Status ☐ permanent ☐ acting (temporary)	Begin Date

D. MEDICAL DIRECTOR

Name – Medical Director	Begin Date

III. OWNERSHIP INFORMATION

A. APPLICANT / LICENSEE

Person(s) or business entity having the authority to direct the management or policies of the facility.

Name – Applicant

Street (physical) Address

City	State	Zip Code	County

Mailing Address (if different from physical address)

City	State	Zip Code	County

Fax Number	Telephone Number

E-mail Address

Contact Person	Telephone Number

B. TYPE OF ORGANIZATION (Check type of ownership.)

Governmental	Proprietary	Voluntary Non-Profit
☐ City ☐ County ☐ State ☐ Federal ☐ City / County ☐ Tribal	☐ Sole Proprietary ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust	☐ Corporation ☐ Church ☐ Association ☐ Church / Corporation ☐ Private Non-Profit ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust

C. INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name		Title	
Street			
City	State	Zip Code	Ownership Percentage
Name		Title	
Street			
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			
City	State	Zip Code	Ownership Percentage

Name		Title	
Street			
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			
City	State	Zip Code	Ownership Percentage

D. The licensee owns the:

OPERATION	☐ Yes	☐ No
BUILDING	☐ Yes	☐ No
LAND	☐ Yes	☐ No

NOTE: If the licensee is <u>not the owner of the operation, building or land</u>, complete the following section or sections as appropriate.

1. OWNER OF THE ☐ OPERATION ☐ BUILDING ☐ LAND

Name – Owner of the Operation or Operation, Building and Land			
Street (physical) Address			
City	State	Zip Code	County
Mailing Address (if different from physical address)			
City	State	Zip Code	County
Telephone Number		Fax Number	
E-mail Address			
Contact Person		Telephone Number	

TYPE OF ORGANIZATION (Check type of ownership.)

Governmental	Proprietary	Voluntary Non-Profit
☐ City	☐ Sole Proprietary	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Association
☐ Federal	☐ Limited Liability Company	☐ Church / Corporation
☐ City / County	☐ Limited Liability Partnership	☐ Private Non-Profit
☐ Tribal	☐ Trust	☐ Limited Liability Company
		☐ Limited Liability Partnership
		☐ Trust

INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name		Title	
Address			
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			
City	State	Zip Code	Ownership Percentage

2. OWNER OF THE ☐ BUILDING ☐ LAND

Name – Owner of the Building or Building and Land			
Street (physical) Address			
City	State	Zip Code	County
Mailing Address (if different from physical address)			
City	State	Zip Code	County
Telephone Number		Fax Number	
E-mail Address			
Contact Person		Telephone Number	

INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name		Title	
Street			
City	State	Zip Code	Ownership Percentage

Name		Title	
Street			
City	State	Zip Code	Ownership Percentage

3. OWNER OF THE ☐ LAND

Name – Owner of the Land			
Street (physical) Address			
City	State	Zip Code	County
Mailing Address (if different from physical address)			
City	State	Zip Code	County
Telephone Number	Fax Number		
E-mail Address			
Contact Person			Telephone Number

INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Attach additional pages if necessary.

Name		Title	
Street			
City	State	Zip Code	Ownership Percentage
Name		Title	
Street			
City	State	Zip Code	Ownership Percentage

4. SUBSIDIARY / PARENT INFORMATION

a. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

☐ Yes ☐ No

If Yes, provide the following information:

Legal Business Name – Parent Company		
DBA (Doing Business As)		
Type of Ownership		
Address		
City	State	Zip Code
Contact Person	Telephone Number	

b. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?

☐ Yes ☐ No

If yes, provide one of the following:

- Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Organizational chart exhibiting the legal business names and, if applicable, the dba name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Complete annual report to shareholders.

5. CHAIN ORGANIZATION

Is the applicant under the control of a chain organization? ☐ Yes ☐ No

Chain organization is defined as multiple providers, and / or suppliers owned, leased, or through any other devises, controlled by a single business entity (defined as chain home office.) Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

If the applicant/licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP), please respond to the following questions:

- Provide the names and addresses of all LLC's, LLP's or any other type of entity that any of the member(s) of the applicant are also members, officers, directors and/or board members.
- Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLC's, LLP's involved with this applicant and its members.

IV. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats.:

A. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home or facility for the developmentally disabled in the State of Wisconsin or in any other state?

☐ Yes ☐ No

IF THE ANSWER IS YES, complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

IF THE ANSWER IS NO, complete questions A – I.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

B. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

☐ Yes ☐ No

If yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to the previous page for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

C. Has any adverse action initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☐ No

If yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to the previous page for abbreviations for type of health care provider.

Facility Name and Address	Location of State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

D. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever had a denial, suspension, enjoining or revocation of a health care provider license, in this state or any other state, as defined in s. 146.81 Wis. Stats., or any conviction for providing health care without a license?

☐ Yes ☐ No

If yes, explain.

E. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under s. 46.90, Wis. Stats.

☐ Yes ☐ No

If yes, explain.

F. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime related to the delivery of health care services or items?

☐ Yes ☐ No

If yes, explain.

G. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving controlled substances under Ch. 161, Wis. Stats.?

☐ Yes ☐ No
If yes, explain.

H. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, had any prior circumstances that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients or residents?

☐ Yes ☐ No
If yes, explain.

I. IDENTIFY THE OTHER TYPES OF PROVIDERS OWNED BY THE APPLICANT / LICENSEE.

If more than two, check here ☐ and attach additional pages.

Name – Provider		
City	State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital, hospice)		

Name – Provider

City	State	Zip Code

Relationship Type (nursing home, home health agency, community based residential facility, hospital)

V. FINANCIAL RESPONSIBILITY

The questions in this section are to be answered **only** by the applicant / licensee.

A. Has the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, been adjudicated bankrupt?

☐ Yes ☐ No

If yes, explain on a separate page. Provide the dates, court and disposition of each action.

B. Are there any unsatisfied judgements against the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP?

☐ Yes ☐ No

If yes, explain on a separate page. Provide the names and addresses of creditors, amounts and the reasons for non-payment.

C. Does the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, owe any debts that are 90 days past due?

☐ Yes ☐ No

If yes, explain on a separate page. Provide the names and addresses of creditors, amounts and reasons for non-payment.

D. Are there any liens filed against the applicant / licensee, any of the interested parties and/or any of the members of a LLC / LLP, or their property?

☐ Yes ☐ No

If yes, explain on a separate page

E. Estimated average gross annual revenues from all sources. Round to the nearest thousand dollars

Daily Rate: Title XIX	$
Private Pay	$
Other	$
Other Revenues	$
TOTAL	$

F. Estimated annual costs. Round to the nearest thousand dollars

Operating Expenses	$
Capital Outlays	$
TOTAL	$

G. HFS 132.14(3)(a)4(c), Wis. Admin. Code requires the applicant to have sufficient financial resources to permit operation of the facility for six (6) months. This amount is one-half of the figure shown in your answer to question F. (estimated annual costs). NOTE: Daily rate charges are automatically taken into consideration.

- Complete the following projected financial statements: (Click on the form number to link to the form.)
  HCF-1022 Instructions for Projected Financial Statements
  Projected Income Statement
  Projected Cash Flow
  Related Party Transactions
  Projected Balance Sheet

- Include the following information (if applicable):
  1. Certified statement of line of credit; or
  2. Personal financial statement along with a signed affidavit committing personal resources or a copy of the corporation's annual report along with a signed affidavit committing corporate resources; or
  3. Other financial documentation to support sufficient resources to cover operating losses.

H. Do you have any other commitments to transfer residents from other facility closings or phasedowns?

☐ Yes ☐ No

If yes, explain on a separate page.

I. Provide projected patient days, by month and by type of payer, for the first six months of operation.

J. Please provide the following, if applicable.

- Explain large variances in the projected revenues and/or expenses from those of the current operator's latest cost report.
- Explain changes in occupancy rate or mix from those of the current owner's latest cost report.
- Provide proof of commitment of mortgages when the purchase of the real estate is involved in the change of ownership.
- Evidence of commitment of a working capital loan and/or a line of credit from the financial institution providing financing.

VI. APPLICANT / LICENSEE

If the applicant/licensee has never been licensed to operate a nursing home in Wisconsin, we request that you respond to the following:

1. Provide resumes for each officer (if the applicant is a corporation), or each partner (if partnership) or member (if limited liability company), etc. to assist the Department in determining the applicant's ability to operate a long term care facility.

2. Is your licensed Nursing Home Administrator (NHA) in good standing in Wisconsin? What nursing facilities has this individual directed and what time periods and bed size? What accomplishments has the NHA achieved?

VII. MANAGEMENT COMPANY

A. Is the operation of the facility under a management contract?

☐ Yes ☐ No

If yes, provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company: ☐ Corporation ☐ Partnership ☐ LLC ☐ Other _____

Name - Management Company		
Name - Contact Person	Telephone Number	
Address		
City	State	Zip Code

B. Identify officers, directors, trustees or supervisors of the management company. Attach additional pages if necessary.

Name	Title	
Address		
City	State	Zip Code
Name	Title	
Address		
City	State	Zip Code

C. Identify other facilities the management company has owned, operated or managed in the last 5 years. Attach additional pages if necessary.

Name		
Address		
City	State	Zip Code
Dates of Involvement		
Name		
Address		
City	State	Zip Code
Dates of Involvement		
Name		
Address		
City	State	Zip Code
Dates of Involvement		

D. While managing any of the above facilities identified in item C.:

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

☐ Yes ☐ No

If yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to page 6 for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

2. Has any adverse action been initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☐ No

If yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to page 6 for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

E. If there is a management company involved, how will you monitor the success of this management company in complying with HFS 132, Wisconsin Administrative Code, and CFR (Code of Federal Regulation)? Provide resumes for each individual of the management company who will exercise operational or managerial control in the long term care facility.

F. Attach a copy of the signed contract with the management company.

VII. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name

Title

Telephone Number	FAX Number	Date Application Completed

I understand, under penalty of law that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed 6 years, or both (946.32 Wis. Stats.).

SIGNATURE IN FULL – Applicant (Potential Licensee)	Print Applicant's Name
Title – Applicant	Date Signed

NOTE: The Management Company cannot attest to or sign on behalf of the applicant (potential licensee).

RETURN THE COMPLETED APPLICATION TO:
Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
PO Box 2969
Madison WI 53701-2969